Mental health and mental health care in Latin America

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Latin America includes in geo-political terms thirteen countries in South America, six in Central America, Mexico, and thirteen located in the Caribbean Basin. Its total population reaches 513 million people, 60% of whom (almost 346 million) live in South America (with Brazil, Argentina and Colombia the most populated), and 20% (almost 99 million) in Mexico; Guatemala has the highest numbers in Central America (11 million), and Cuba (11 million), Dominican Republic and Haiti (8 million each) surpass the rest of the Caribbean countries. Spanish is the official language in seventeen countries of the region, Portuguese in Brazil (with almost 30% of the total population), and French, English, Flemish and a variety of dialects are spoken in the remainder thirteen countries, particularly the Caribbeans. It is said that more than 90% of the population is Catholic, but in recent decades Protestant churches seem to be making significant inroads, while folk religions and cults are still practiced by an estimated 15 million people in rural and isolated areas of the subcontinent.

More than 40% of the Latin American population was 15 years or younger in the year 2000, while individuals 60 years or older constituted up to 10% of the total. Women have almost six more years of life expectancy than men (74.1 vs. 68.7). It is estimated that both men and women in the region have already lost at least 10 years of life by the time of birth, compared to their counterparts in Europe and North America. This demographic picture, published by the World Health Organization (1), occurs against a background of approximately 36% of the Latin American population living below poverty levels in urban areas, and 10% in rural areas. Some countries, like Honduras, reach 74% in this parameter, in contrast to Chile or Costa Rica that show 20% or less. This all dramatizes the extraordinary disparities of wealth and income across the subcontinent: the greatest majority of people face significant economic deprivation, closely related to languishing job markets, low educational levels (only 15 to 20% of the total population obtain college degrees), deficient social infrastructure, and weak political stability.

More than half (54.9%) of health expenditures originate from the public sector. The social security sector is strong in Mexico (70.4%) and almost non-existent in the Caribbean subregion (3%). The majority of Latin American countries, however, devote less than 2% of their total health budget to mental health, thus compounding a dismal picture already affected by everyday stresses of all kinds (from massive internal migrations to a 'hidden epidemic' of domestic violence or from socio-political unrest to the ever-present risk of natural disasters). Even worse, the precarious budget allocations are primarily devoted to long-term cases, leaving meager resources for ambulatory care. This is aggravated by deeply rooted cultural characteristics, particularly those related to shame and guilt in the perception of cases of mental illness among families, distorted help-seeking patterns, religious and folk beliefs about causes and treatment, and the sheer unavailability of appropriate mental health services (2). The latter leads to ostensible violations of human rights of patients and families, even more evident if issues such as blatant deficiencies in the physical plants of psychiatric facilities where patients are housed, or an assortment of insults to their human dignity (quality of food or cover, anonymity, overt or covert mistreatment, social neglect, lack of organized activity) are taken into account.

Several epidemiological studies in the region have shown a consistent prevalence of 18-25% of mental disorders in communities, up to a 27-48% range in clinical settings (3). Between 12 and 29% of diagnosed or diagnosable conditions are detected in children and adolescents. For the year 2010, 35 million new cases per year are predicted; this will result in a glut of mental health facilities, and will be even worse if current levels of attention (only 1 out of 5 patients in need of treatment, actually receive it) are maintained. Depression and anxiety in all their clinical variants, plus somatoform and alcohol and drug abuse disorders (the latter, more than 20% of the estimated prevalence), in addition to the so-called "major" psychiatric disorders, are the most frequent risks.

Applying the Burden of Disease (BD) crite-

ria to Latin American populations (4,5), the rubric of intentional injuries has 12% of its world total in this subcontinent, moving up to 29.2% when the injuries are explicitly related to acts of violence. Furthermore, Latin America shows 10.5% of the world total BD due to neuropsychiatric disorders: unipolar depression represents 35.7% among psychiatric entities, and alcoholism 18.2%, followed by schizophrenia (7.8%), bipolar affective disorder (6.6%), and substance abuse (5.6%). In the year 2000, 18 million people in the region suffered financially serious setbacks (unemployment, job dismissals, eviction, homelessness) as a result of clinically significant mental disorders.

In response to several pronouncements by international organizations, particularly the Pan American Health Organization (PAHO), that in 1990 reformulated - through a document called the Declaration of Caracas - the philosophy and orientation of mental health services in the region (6,7), 64.5% of Latin American countries have specific mental health policies, 80.6% have plans and programs, 67.9% have specific mental health legislation, and 87.1% provide disability benefits for psychiatric patients. What is not well documented is whether such instruments are effectively implemented and utilized. Countries such as Mexico, Chile, Costa Rica and Brazil have made clear advances in this area.

Recently, the same organizations have emphasized the necessity of decentralized policies, the involvement of community and primary care as crucial vehicles in the provision of mental health, a multidisciplinary approach to the care of the mental patients and their families, strong educational efforts, and consistent defense of human rights (8).

Human mental health resources in Latin America are very scarce. The estimated figures of 1.6 psychiatrists, 2.7 psychiatric nurses, 2.8 psychologists, and 1.9 social workers per 100,000 are far below those of Europe or the US (1,9,10). The greater concentration of these professionals in metropolitan areas leave unattended at least 45% of the total population in need. On the other hand, patients are seen first by non-professionals, second by non-psychiatric professionals, and only last by mental health professionals. Needless to say, insurance coverage is minimal, and mental health professionals are among the lowest paid in most countries. Their training takes place in insufficient facilities with limited teaching staffs, scarce equipment, and loose monitorization by academic centers or governmental agencies (11). In spite of a slight growth in absolute numbers of psychiatric vocations, for instance, the risk of emigration by future trainees is still present. Some countries - like Argentina, Chile, Brazil and Venezuela - are attempting to create international training consortia in the region, taking advantage of their respective strengths and making better use of technological innovations (12).

In Latin America there are approximately 3.3 psychiatric beds per 10,000 inhabitants. 47.6% of these beds are in psychiatric hospitals, 16.8% in general hospitals, and 35.6% in other community settings (13). Only three countries have more than 50% of their beds in general hospitals and residential settings. On the other hand, 86.7% of the countries have policies related to supply and provision of psychotropic agents, but more than 1/3 experience significant problems in the actual implementation of such policies.

In the last three or four decades, there have been significant efforts of mental health promotion and prevention in several Latin American countries. In Mexico, for instance, patients, families and communities have participated in interactive educational activities with assistance from non-governmental organizations. The literature has also documented successful experiences in countries such as Brazil, Honduras, Colombia, Venezuela, Argentina, Cuba, Chile and Bolivia (14).

Mental health research in Latin America has made some progress, but much remains to be done. Brazil, Argentina, Mexico and Chile are ahead in resources and productivity (15), but Mexican authors publish more consistently, in spite of a proportionately lower budget than the other three countries (US$ 20 per capita vs. 60 in Brazil; in the U.S. the assignment is US$ 827 per capita) (16). Eight countries have institutes theoretically devoted to mental health research, but only one (Mexico) works consistently towards such goal. The others may have the infrastructure but lack in policies, rules, operational systems and qualified personnel. The absence of solid financial support by the government seems to be at the root of this discouraging reality.

The above notwithstanding, Latin American psychiatry has produced significant research contributions, particularly in the areas of epidemiology, clinical studies, cultural issues, and psychopharmacology. There is an intense debate on the fate of basic research in the subcontinent, with slight dominance of those who advocate a social and clinical orientation more closely related to the actual plight of the majorities (17,18).

Among the most urgent needs of mental health operations in Latin America, the following are included: a) more support of provision of care, training and research through inter-sectorial alliances and initiatives; b) integration of mental health and primary care services and fostering of promotion and prevention activities; c) increase of the mental health workforce with multidisciplinary bases and appropriate geographic distribution; d) sharing and dissemination of applied research findings from collaborative centers of excellence in the region; e) implementation and improvement of effective mental health policies aimed at an adequate distribution of resources, establishment of priorities, and increased public sophistication on mental health matters; f) financial collaboration and technical support from international agencies and organizations.

References

1. World Health Organization. The World Health Report 2001. Mental health: new understanding, new hope. Geneva: World Health Organization, 2001.
2. Kirmayer L, Minas H. The future of cultural psychiatry: an international perspective. Can J Psychiatry 2000;45:438-46.
3. De Almeida Filho N, Canino G. Epidemiología psiquiátrica. In: Vidal G, Alarcón RD, Lolas F (eds). Enciclopedia iberoamericana de psiquiatría, Vol. 2. Buenos Aires: Editorial Médica Panamericana, 1995:487-501.
4. Murray CJL, Lopez AD. The global burden of disease. Cambridge: Harvard University Press, 1996.
5. Üstün TB. The global burden of mental disorders. Am J Publ Health 1999;89:1315-8.
6. Organización Panamericana de la Salud. Salud para todos en el año 2000. Plan de acción para la instrumentación de las estrategias regionales. Washington: Organización Panamericana de la Salud, 1982.
7. Levav I, Lima BR, Somoza-Lennon M et al. Salud mental para todos en América Latina y el Caribe. Bases epidemiológicas para la acción. Bol Sanit Panam 1989;107:196-219.
8. Vasquez J. Promoción y protección de los derechos humanos básicos de las personas con discapacidades mentales y sus familiares. Presented at the Conference on Mental Health in the Americas: Partnering for Progress, Washington, November 2001.
9. Alarcón RD. Hispanic psychiatry: from margin to mainstream. Transcult Psychiatry 2001;38:5-25.
10. Saraceno B, Saxena S. Mental health resources in the world: results from Project ATLAS of the WHO. World Psychiatry 2002;1:40-4.
11. Gonzalez R. Salud mental en la comunidad en América Latina. Ejemplo de programas. In: Levav I (ed). Temas de salud mental en la comunidad. Washington: Organización Panamericana de la Salud, 1992:291-312.
12. Academia Nacional de Medicina de Buenos Aires. Seminario-Taller sobre la formación del psiquiatra y su certificación. Buenos Aires: Prensa Médica Argentina, 2000.
13. Alarcón RD. Mental health in Latin America, circa 2001-2002. In: Sepúlveda J (ed). Salud panamericana. Mexico: Instituto Nacional de Salud Pública, 2002:114-26.
14. Vergara C. El contexto de las reformas del sector de la salud. Rev Panam Salud Pública 2000;8:7-12.
15. Pucheu C, Torres J, de la Fuente JR. Marcos de referencia para la investigacion socio-médica psiquiátrica. Salud Mental 1985;8:8-15.
16. Mari JJ. Mental health research in Latin America. Presented at the Conference on Mental Health in the Americas: Partnering for Progress, Washington, November 2001.
17. Alarcón RD. Perspectivas de la investigación psiquiátrica en América Latina. Acta Psiq Psicol Am Latina 1993;39:19-31.
18. Murray CJL, Gakidou EE, Frenk J. Health inequalities and social group differences: what should we measure? WHO Bull 1999;77:537-43.